Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2726AGC	A. BUILDING _____ B. WING _____	11/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMELA HOMES	5500 CLEARY CT LAS VEGAS, NV 89108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments This Statement of Deficiencies was generated as a result of the annual state licensure survey conducted at your facility on 11/7/08. This survey was conducted using Nevada Administrative Code (NAC) 449, Residential Facility for Groups Regulations, adopted by the Nevada State Board of Health on July 14, 2006. The facility was licensed for 6 Category 2 beds. The facility had an endorsement to care for elderly and/or disabled persons. The facility had an endorsement to care for persons with mental illnesses. The census at the time of the survey was 6. Six resident records were reviewed. Four employee files were reviewed. There were no complaints investigated during the survey. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	Y 000		
Y 070 SS=D	449.196(1)(f) Qualifications of Caregiver-8 hours training NAC 449.196 1. A caregiver of a residential facility must:	Y 070		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2726AGC	A. BUILDING _____ B. WING _____	11/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMELA HOMES	5500 CLEARY CT LAS VEGAS, NV 89108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 070	Continued From page 1 (f) Receive annually not less than 8 hours of training related to providing for the needs of the residents of a residential facility. This Regulation is not met as evidenced by: Based on record review, the facility failed to ensure eight hours of training related to providing for the needs of the residents was received annually by 1 of 4 employees (#2). Findings include: Employee #2 was hired as the Administrator on 8/9/95. Employee #2's file lacked documented evidence of eight hours of training related to caring for elderly or disabled persons and persons with mental illness for the past year. Severity: 2 Scope: 1	Y 070		
Y 100 SS=B	449.200(1)(a) Personnel File - Employee Info NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (a) The name, address, telephone number and social security number of the employee. This Regulation is not met as evidenced by: Based on record review and interview, the facility failed to maintain separate personnel files for 2 of 4 employees (#3, #4). Findings include:	Y 100		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2726AGC	A. BUILDING _____ B. WING _____	11/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMELA HOMES	5500 CLEARY CT LAS VEGAS, NV 89108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 100	Continued From page 2 On 11/7/08 at 1:00 PM, a three ring binder contained the records of Employee #3 and Employee #4. Employee #1 pointed out the documents were separated by a tab. Severity: 1 Scope: 2	Y 100		
Y 103 SS=E	449.200(1)(d) Personnel File - NAC 441A NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee. This Regulation is not met as evidenced by: Sec. 10. NAC 441A.375 is hereby amended to read as follows: 441A.375 1. A case having tuberculosis or suspected case considered to have tuberculosis in a medical facility or a facility for the dependent must be managed in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 2. A medical facility, a facility for the dependent or a home for individual residential care shall maintain surveillance of employees of the facility or home for tuberculosis and tuberculosis infection. The surveillance of employees must be conducted in accordance with the recommendations of the	Y 103		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2726AGC	A. BUILDING _____ B. WING _____	11/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMELA HOMES	5500 CLEARY CT LAS VEGAS, NV 89108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 103	Continued From page 3 Centers for Disease Control and Prevention for preventing the transmission of tuberculosis in facilities providing health care set forth in the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 3. Before initial employment, a person employed in a medical facility, a facility for the dependent or a home for individual residential care shall have a: (a) Physical examination or certification from a licensed physician that the person is in a state of good health, is free from active tuberculosis and any other communicable disease in a contagious stage; and (b) Tuberculosis screening test within the preceding 12 months, including persons with a history of bacillus Calmette-Guerin (BCG) vaccination. If the employee has only completed the first step of a 2-step Mantoux tuberculin skin test within the preceding 12 months, then the second step of the 2-step Mantoux tuberculin skin test or other single-step tuberculosis screening test must be administered. A single annual tuberculosis screening test must be administered thereafter, unless the medical director of the facility or his designee or another licensed physician determines that the risk of exposure is appropriate for a lesser frequency of testing and documents that determination. The risk of exposure and corresponding frequency of examination must be determined by following the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 4. An employee with a documented history of a positive tuberculosis screening test is exempt from screening with skin tests or chest radiographs unless he develops symptoms	Y 103		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2726AGC	A. BUILDING _____ B. WING _____	11/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMELA HOMES	5500 CLEARY CT LAS VEGAS, NV 89108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 103	Continued From page 4 suggestive of tuberculosis. 5. A person who demonstrates a positive tuberculosis screening test administered pursuant to subsection 3 shall submit to a chest radiograph and medical evaluation for active tuberculosis. 6. Counseling and preventive treatment must be offered to a person with a positive tuberculosis screening test in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (g) of subsection 1 of NAC 441A.200. 7. A medical facility shall maintain surveillance of employees for the development of pulmonary symptoms. A person with a history of tuberculosis or a positive tuberculosis screening test shall report promptly to the infection control specialist, if any, or to the director or other person in charge of the medical facility if the medical facility has not designated an infection control specialist, when any pulmonary symptoms develop. If symptoms of tuberculosis are present, the employee shall be evaluated for tuberculosis. Based on record review, the facility failed to ensure TB testing was completed for 3 of 4 employees (#1, #2). Findings include: Employee #1 was hired as a caregiver on 10/17/05. Employee #1's file lacked evidence of TB testing or surveillance for 2007. Note: There was documentation of negative chest x-ray results, dated 4/3/08. Employee #2 was hired as the Administrator on 8/9/95. Employee #2's file contained documented evidence of a positive TB skin test on 9/25/90. The file lacked documented	Y 103		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2726AGC	A. BUILDING _____ B. WING _____	11/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMELA HOMES	5500 CLEARY CT LAS VEGAS, NV 89108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 103	Continued From page 5 evidence of TB surveillance for the past two years. Severity: 2 Scope: 2	Y 103		
Y 530 SS=F	449.260(1)(e) Activities for Residents NAC 449.260 (e) Provide for the residents at least 10 hours each week of scheduled activities that are suited to their interests and capacities. This Regulation is not met as evidenced by: Based on observation and interview, the facility failed to provide 10 hours of activities per week for 6 of 6 residents. Findings include: The calendar posted had activities listed for each day. There was no time posted for each of the activities. On 11/7/08 at 8:45 AM, Resident #1 responded, "No we never have any activities here...in fact, I wish we did - that would be great!" On 11/7/08, Employee #1 indicated the residents are usually not interested in any group activities. Severity: 2 Scope: 3	Y 530		
Y 870 SS=E	449.2742(1)(a)(1) 449.2742(1)(a)(1) Medication Administration	Y 870		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2726AGC	A. BUILDING _____ B. WING _____	11/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMELA HOMES	5500 CLEARY CT LAS VEGAS, NV 89108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 870	Continued From page 6 NAC 449.2742 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall: (a) Ensure that a physician, pharmacist or registered nurse who does not have a financial interest in the facility: (1) Reviews for accuracy and appropriateness, at least once every 6 months the regimen of drugs taken by each resident of the facility, including, without limitation, any over-the-counter medications and dietary supplements taken by a resident. This Regulation is not met as evidenced by: Based on record review, the facility failed to ensure a medication review was obtained every 6 months for 3 of 6 residents. Findings include: Resident #2 was admitted on 4/5/07 with diagnoses including bladder cancer and coronary artery disease. The record for Resident #2 contained a medication review dated 4/30/08. The record lacked documented evidence of medication reviews for the past year (due 10/07 and 10/08). Resident #3 was admitted on 1/10/06 with diagnoses including congestive heart failure, osteoarthritis, glaucoma, macular degeneration, Parkinson's disease and dementia.	Y 870		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2726AGC	A. BUILDING _____ B. WING _____	11/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMELA HOMES	5500 CLEARY CT LAS VEGAS, NV 89108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 870	Continued From page 7 The record for Resident #3 contained a medication review dated 7/26/07. The record lacked documented evidence of a medication review, due in January 2008. Resident #4 was admitted on 11/15/05 with diagnoses including non-insulin dependent diabetes mellitus and paranoid schizophrenia. The record for Resident #4 contained a medication review dated 1/19/07. The record lacked documented evidence of a medication review in July 2007 and January 2008. Severity: 2 Scope: 2	Y 870		
Y 911 SS=D	449.2746(2)(d) PRN Medication Record NAC 449.2746 2. A caregiver who administers medication to a resident as needed shall record the following information concerning the administration of the medication: (d) The results of the administration of the medication. This Regulation is not met as evidenced by: Based on record review and interview, the facility failed to document the results of a medication for 1 of 5 residents (#3). Findings include: Resident #3 was admitted on 1/10/06 with diagnoses including senile dementia, congestive heart failure and Parkinson's disease.	Y 911		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2726AGC	A. BUILDING _____ B. WING _____	11/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMELA HOMES	5500 CLEARY CT LAS VEGAS, NV 89108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 911	Continued From page 8 Resident #3 had orders for Haldol 1 milligram 1 tablet by mouth at bedtime as needed (PRN) for anxiety. The PRN Medication Notes contained an entry for 10/18/08 and 10/19/08. On both dates, the resident was given a dose of Haldol for anxiety. The file lacked documented evidence of the results of the medication. Employee #1 acknowledged follow up documentation was required. Severity: 2 Scope: 1	Y 911		
Y 936 SS=F	449.2749(1)(e) Resident file NAC 449.2749 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including without limitation: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. This Regulation is not met as evidenced by: Based on record review, the facility failed to ensure proper Tuberculosis (TB) skin testing or surveillance had been done for 4 of 6 residents (#1, #2, #3, #5). Findings include: Resident #1 was admitted on 6/24/08. The	Y 936		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2726AGC	A. BUILDING _____ B. WING _____	11/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMELA HOMES	5500 CLEARY CT LAS VEGAS, NV 89108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 936	Continued From page 9 record lacked documented evidence of a positive TB skin test. The record contained documented evidence of a chest x-ray completed on 6/17/08. The results of the chest x-ray lacked any mention of TB. Resident #2 was admitted on 4/5/07. The record contained results of a 2-step TB skin test, completed on 4/23/07. The record lacked documented evidence of an annual 1-step TB skin test for the past year. Resident #3 was admitted on 1/10/06. The record contained results of a 2-step TB skin test, completed on 8/3/05. The record contained documented evidence of a 2-step TB skin test which had started on 8/31/06. The record lacked documented evidence of a 1-step TB skin test for 2007. The record contained documented evidence of a 1-step TB skin test completed on 8/2/08. Resident #5 was admitted on 3/23/08. The record lacked documented evidence of a positive TB skin test. The record contained documented evidence of a chest x-ray completed on 3/21/08. The results lacked any mention of the resident being free of TB. Severity: 2 Scope: 3	Y 936		
YA930 SS=F	449.2749(1)(a-j) Resident File NAC 449.2749 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against	YA930		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2726AGC	A. BUILDING _____ B. WING _____	11/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMELA HOMES	5500 CLEARY CT LAS VEGAS, NV 89108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
YA930	Continued From page 10	YA930		

unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including without limitation:
(a) The full name, address, date of birth and social security number of the resident.
(b) The address and telephone number of the resident's physician and the next of kin or guardian of the resident or any other person responsible for him.
(c) A statement of the resident's allergies, if any, and any special diet or medication he requires.
(d) A statement from the resident's physician concerning the mental and physical condition of the resident that includes:
(1) A description of any medical conditions which require the performance of medical services;
(2) The method in which those services must be performed; and
(3) A statement of whether the resident is capable of performing the required medical services.
(e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto.
(f) The types and amounts of protective supervision and personal services needed by the resident.
(g) An evaluation of the resident's ability to perform the activities of daily living and a brief description of any assistance he needs to perform those activities. The facility shall prepare such an evaluation:
(1) Upon the admission of the resident;
(2) Each time there is a change in the mental or physical condition of the resident that may significantly affect his ability to perform the activities of daily living; and
(3) In any event, not less than once each year.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2726AGC	A. BUILDING _____ B. WING _____	11/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMELA HOMES	5500 CLEARY CT LAS VEGAS, NV 89108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
YA930	Continued From page 11 (h) A list of the rules for the facility that is signed by the administrator of the facility and the resident or a representative of the resident. (i) The name and telephone number of the vendors and medical professionals that provide services for the resident. (j) A document signed by the administrator of the facility when the resident permanently leaves the facility. This Regulation is not met as evidenced by: Based on interview and record review, the facility failed to ensure all documentation was maintained for 6 of 6 residents (#1, #2, #3, #4, #5, #6). Findings include: Resident #1 was admitted on 6/24/08. The file lacked documented evidence of: 1) a rate agreement signed by the Administrator and resident; 2) a statement from the physician concerning the mental and physical condition of the resident; and 3) the amount and type of protective supervision needed by the resident. Resident #2 was admitted on 4/5/07. The file lacked documented evidence of: 1) a rate agreement signed by the Administrator and resident; 2)) a statement from the physician concerning the mental and physical condition of the resident; and 3) the amount and type of protective supervision needed by the resident.	YA930		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2726AGC	A. BUILDING _____ B. WING _____	11/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMELA HOMES	5500 CLEARY CT LAS VEGAS, NV 89108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
YA930	Continued From page 12 Resident #3 was admitted on 1/10/06. The file lacked documented evidence of: 1) house rules signed by the Administrator and resident; 2) a statement from the physician concerning the mental and physical condition of the resident; and 3) the amount and type of protective supervision needed by the resident. Resident #4 was admitted on 11/15/05. The file lacked documented evidence of: 1) a statement from the physician concerning the mental and physical condition of the resident; and 2) the amount and type of protective supervision needed by the resident. Resident #5 was admitted on 3/23/08. The file lacked documented evidence of: 1) house rules signed by the Administrator and resident; 2) a statement from the physician concerning the mental and physical condition of the resident; and 3) the amount and type of protective supervision needed by the resident. Resident #6 was admitted on 10/15/08. The file lacked documented evidence of a rate agreement signed by the Administrator and resident. Employee #1 indicated there were no rate agreements because the pay source was Clark County Social Services (for Residents #1, #2, #6). Severity: 2 Scope: 3	YA930		